STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of Lake Ridge
Health Care Center - Survey
Date March 15, 2005

RECOMMENDED DECISION

The above-entitled matter was the subject of an informal independent dispute resolution (IIDR) meeting conducted by Administrative Law Judge Richard C. Luis on Thursday, June 23, 2005, beginning at 9:30 a.m., at the Office of Administrative Hearings. The meeting concluded on that date. The review record was closed at the conclusion of the meeting on June 23, 2005.

Michael Marchant, Administrator, 2727 North Victoria Street, Roseville, 55133, represented Lake Ridge Health Care Center (Lake Ridge or Facility). Appearing at the meeting for the Department of Health (Department or Health) were Margie Martenson, Office of Health Facility Complaints (OHFC), and Mary Cahill, Principal Planner for the Department of Health (Department), 85 East 7th Place, Saint Paul, MN 55101.

Also appearing at the meeting were Joy Hellen, Director of Nursing Services (DNS) at Lake Ridge, Pat Voelker, Assistant Administrator and LSW for Beverly Healthcare, Sherri Lage, Program Manager of the Alzheimer's Care Unit at Lake Ridge, and Randi Hansen, Consultant for Beverly Healthcare.[1]

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

Based on the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

1. That the citations for deficiency number F224 regarding resident 12 and 16 are supported by the facts, but the scope and severity level is not supported by the facts and should be amended to Level D for both.

Deficiency number F224 regarding resident 17 is not supported by the facts and should be dismissed. Deficiency number F224 regarding resident 20 is supported by the facts and the scope and severity level of the deficiency was correctly assigned to Level K.

2. That the citations for deficiency number F250 for Residents 3, 12, 16, and 17 are not supported by the facts and should be dismissed. The deficiency number F250 for Resident 20 is supported by the facts, but the scope and severity level is not supported by the facts and should be amended to Level A.

3. That the citations for deficiency number F309 are supported the by evidence. The scope and severity level for the deficiency for Resident 22 is appropriately Level G. The scope and severity level for the deficiency for Resident 4 is not supported by the facts and should be amended to Level D.

Dated: July 6, 2005

/s/ Richard C. Luis
RICHARD C. LUIS
Administrative Law Judge

Reported: Tape-recorded
(Two Tapes, No Transcript Prepared)

MEMORANDUM

OHFC conducted a survey of Lake Ridge on March 15, 2005. Based on this survey, OHFC declared an Immediate Jeopardy situation concerning four residents. OHFC also issued a Statement of Deficiencies identifying those and additional violations. The deficiencies under Tag F224 were assigned a scope level of "pattern" and a severity level of immediate jeopardy (Level "K").[2] Another deficiency found for each of those four residents and one additional resident, Tag F250, was assigned a scope level of "pattern" and a severity level of actual harm (Level "H").[3] Two deficiencies were identified regarding pain management for which Tag R309 was issued, and assigned a scope level of "isolated" and a severity level of actual harm (Level "G").[4] The Facility appealed the deficiencies.

The survey process operates under the overall authority of the Centers for Medicaid and Medicare Services ("CMS"). CMS is a division of the U.S. Department of Health and Human Services. CMS holds facilities to a standard of substantial compliance. "Substantial compliance" is defined as:

> A level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. 42 C.F.R. § 488.301

When citing deficiencies, surveyors use the CMS "Chart of Enforcement Remedies" (commonly referred to as the "Scope and Severity Grid" or "the Grid"). The level of deficiency and the enforcement action to be taken is set out on each square of the Grid. The scope axis ranges from isolated (level 1), pattern (level 2), or widespread (level 3). The severity axis has four levels ranging from immediate jeopardy (most severe or level 4) to no actual harm with potential for minimal harm (least severe or level 1). Each square on the Grid has a letter designation. A is the least serious, and L is the most serious.

F224 and F250

Four residents are identified in the F224 tag. Those four residents and one additional resident are identified in the F250 tag. The underlying facts for the combined tags are essentially the same and those tags will be addressed together.

Resident 12

Resident 12 is an Air Force veteran who worked in corrections before retirement. He is 81 years old and suffering from depression, malaise and fatigue, and an adult failure to thrive, along with a variety of physical ailments. Resident 12 is married, but his spouse is unable to care for him at home. He desires to return home, but he knows that this is an unrealistic desire.[5] His history of depression dates to his retirement in 1984, when Resident 12 attempted suicide by smothering himself with a plastic bag. He also attempted suicide by Tylenol overdose in 2001. [6]

Prior to July 2004, Resident 12 had been in Lake Ridge and one other nursing home. In July 2004, he returned to Lake Ridge. An initial Minimum Data Set was established on Resident 12, noting his depression and assessing his decision-making skills as "Modified Independence – some difficulty in new situations." Resident 12's mood indicators were assessed as "not easily altered." His expressed preference was for reading in his room.[7]

Nursing notes beginning on July 16, 2004, reflected that Resident 12 was "crying" and "very despondent." The nurse compared Resident 12's prescriptions from his prior stay and noted differences with his then current prescriptions. The nurse checked with his doctor to confirm appropriate dosages.[8] The inquiry was prompted by concern over increased signs of depression compared to Resident 12's prior admission.[9]

On July 19, 2004, the notes reflect staff's efforts to get Resident 12 out of bed and moving around the facility.[10] Staff were instructed at that time to watch for increased signs of depression. [11] On July 28, 2004, Resident 12 expressed unhappiness at being in the nursing home and described his being there as, "feels like a

prisoner."[12] His mood was described as "depressed" and the nursing notes reflect that he refused to get out of bed.[13]

Staff developed a plan of care, reviewed quarterly, that included a number of interventions for staff to emphasize in providing care to Resident 12. On August 15, 2004, two interventions, providing encouragement to get out of bed and positive reinforcement when out of bed, were added to the plan of care.[14]

On August 4, 2004, Resident 12 stated, "I'm feeling good today."[15] In September, Resident 12 was hospitalized for surgery. During this period and upon his return to Lake Ridge on September 27, 2004, both Resident 12 and his spouse expressed "no concerns." [16]

On October 5, 2004, nursing notes reflected that Resident 12 had been cooperating in therapy and his mood had improved. On October 9, 2004, his mood was described as "sarcastic."[17]

On October 10, 2004, Resident 12 reported feeling depressed and was crying. He told a staffer that he did not "want to live anymore." [18] He also said that he "took a pen to his wrists."[19] No injury to Resident 12 was apparent. Staff called the Veteran's Administration Medical Center (VAMC) and Resident 12 was transported there immediately. His admission note included "SI [suicide ideation] w/thoughts of hurt. self w/pen today."[20]

On October 12, 2004, Resident 12 returned from the VAMC. He spoke with staff the next day, and denied that he had wanted to kill himself, said he felt much better, and that he was glad to be back at Lake Ridge.[21] A care conference was conducted on October 14, 2004. Resident 12's plan of care was updated to have daily and as needed social worker visits. The listed interventions were modified to add observation and charting of behavior, visiting daily to discuss feelings, updating his doctor on changes in mood and behavior, and involving a psychiatrist as needed.[22] Resident 12's mood was observed to have improved on October 15, 2004.

On October 18, 2004, Resident 12 was agitated, arguing with staff about a care (possibly a medication) he had already received. Resident 12 want to contact two female staff members' husbands to complain about their behavior. Later, he indicated that he wanted to sue the facility.[23] All of the foregoing conduct was noted by staff.

On November 3, 2004, Resident 12 refused to get up for breakfast or lunch. He expressed detachment from the world and stated that there was a better place than this world. His statements were charted.[24] During the period from November 3 to 15, staff noted Resident 12's condition every day, including a notation regarding a fall that did not result in an injury. On November 17, 2004, Resident 12 complained of pain in his groin area. He told staff "either send me to the hospital or to the cemetery, I don't want to stay here."[25] On November 18, 2004, Resident 12 asked for assistance in walking, and the staff member asked him to wait until another staffer could also assist. Resident

12 responded saying, “you never helped me,” and he threatened to hit the staffer with a grabber.[26]

Staffers continued to consistently chart Resident 12’s condition, including notes on his staying in bed and making statements such as “I want out of this fucking place . . . I want to die.”[27] These outbursts appear to have been prompted by pain, not depression.[28] On December 2, 2004, Resident 12 refused to get **into** bed. He stayed in a chair in his room.

On December 8, 2004, Resident 12 refused his medications at 3:00 p.m. By 4:15 p.m., Resident 12 had become emotional and asked to speak to the head nurse. The facility’s nurse and social worker both responded. Resident 12 expressed feelings of hopelessness. The nurse accompanied Resident 12 to the dining room and spent 90 minutes in one to one care. His mood improved and the nurse noted the plan was to “continue to monitor.”[29]

Later notes indicated that Resident 12 did not get out of bed on December 22 and 23, 2004, and he made the comment that he was “already dead.”[30] On December 24, 2004, the nursing note states “0 talk of ~~depr~~ [error] suicide.”[31]

At 2:00 a.m. on January 2, 2005, Resident 12 wrapped his nightgown around his neck and attempted to choke himself. Staff intervened and his physician ordered him hospitalized at the VAMC. Resident 12 was initially transported to the Regions Hospital Emergency Room.[32] The notes on the incident took up two pages and included references to how Resident 12’s mood was positive prior to the suicide attempt.[33] In talking with a physician a few days later, Resident 12 denied that he was suicidal, indicating that such thoughts just come over him at times. He also described himself as “impulsive.”[34]

Resident 12 returned to Lake Ridge on January 5, 2005. His plan of care was updated to note his history of suicide attempts. The listed interventions were amended to include “monitor and chart any negative statements/behaviors” and “notify MD of any suicidal ideation/attempts.” Another plan of care update was made to note that he is to be seen regularly by a VA psychiatrist. A directive that social services was to be kept aware of any increased behaviors was added to the listed interventions.[35]

On January 10, 2005, Resident 12 was seen by a VA psychiatrist who noted that Resident 12 “appears to be stable and reports no problem with nursing home.”[36] There were no particular actions ordered by the psychiatrist for Lake Ridge staff to follow regarding Resident 12. Nursing notes on January 20 and 22 indicated that Resident 12 did not express any suicidal thoughts.[37] Resident 12 later commented that he is going to die because he is 80 years old.[38] The consistent nursing note charting stopped at January 30, 2005.

The Facility social worker charting reflects visits to Resident 12 at about every six days since his return on January 5, 2005. No problems were noted. The last notation in this period is of a visit on February 4, 2005.[39]

On February 7, 2005, Resident 12 was again seen by a psychiatrist. The notes of that consultation reflect that Resident 12 was showing no sign of depression and that he was "doing better."[40] No instructions regarding care were given by the psychiatrist.

The next nursing note was dated February 14, 2005, indicating that Resident 12 slept through the night.[41]

On February 25, 2005, Resident 12 again attempted to choke himself with the pajamas.[42] Staff intervened and Resident 12 was again hospitalized. He returned to Lake Ridge on March 1, 2005. The social worker log reflected much more frequent (almost daily) visits after the last suicide attempt.[43]

The surveyors examined the documentation of Resident 12's care as part of their March 15, 2005 survey. They concluded that Lake Ridge was in violation of 42 C.F.R. 483.13(c) for failure to assess, implement and monitor for self-injurious behavior. The surveyors assigned level K to the deficiency.[44] They also concluded that Lake Ridge was in violation of the quality of life provisions for failure to "provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[45] The surveyors assigned level H to that deficiency.[46]

Nursing homes are required to comply with the standards of resident behavior and facility practices set out in 42 CFR § 483.13, which states:

> Sec. 483.13 Resident behavior and facility practices.
>
> (a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
>
> (b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
>
> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) The facility must—
>
> > (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
> >
> > (ii) Not employ individuals who have been-- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and

(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

At the hearing, Facility staffers indicated that everyone on duty knew to look in on Resident 12 every time they passed in the hallway. There is no evidence that any staff failed to intervene when Resident 12 experienced an episode of depression prompting him to attempt suicide. The surveyors erred in finding that Resident 12 suffered either physical or emotional harm from his interrupted attempts at self-injury.[47] Resident 12's mood improved markedly after each of his attempts. The detail in the earlier charting on Resident 12 reflects the unpredictable and episodic nature of his condition. The surveyors erred in finding that the deficiency supported an immediate jeopardy finding. The evidence supports insufficient charting of Resident 12's condition from February 4 to February 25, 2005. This violation is isolated and presents a potential for harm that is more than minimal, but not immediate jeopardy and is appropriately assigned a level D on the F224 tag.

Lake Ridge demonstrated that it provided daily social service visits Monday through Friday after the last suicide attempt. The surveyors maintained that there was not quantitative measurement of Resident 12's emotional state regarding the potential for suicide attempts. His entire history of such activity was that it would occur without prior warning and then disappear as if the activity had never been. Adding additional direction during the weekends would not have improved outcomes. The social service intervention has allowed Resident 12 to reach his highest medically attainable state of wellbeing. The surveyors erred in finding that Lake Ridge was not complying with its obligation to provide medically-related social services. The F250 tag regarding Resident 12 is not supported.

Resident 16

Resident 16 is 84-year-old woman who suffers from a variety of ailments that have left her unable to care for herself. She entered Lake Ridge on December 14, 2004. Due to a significant number of documented instances of anxiety, she was referred for a Diagnostic Assessment on January 7, 2005. The licensed psychologist who performed the assessment wrote:

> In the nursing home setting, [Resident 16] has turned out to be a difficult resident to manage. She tends to isolate and has not attended one activity in the facility, although she is invited frequently. She even refuses one-to-one visit[s] from the recreational therapist. She spends a lot of time on the call light and has frequent requests for cough syrup – although there is never any evidence of coughing. Otherwise, she wants to go to the bathroom frequently and may use the call light three or four times to call somebody to use the bathroom. She perhaps actually needs to use the bathroom around 50 percent of the time. She can be up much of the night making requests to nursing staff. She will also call out "Help me! Help me!" [48]

The initial psychological assessment included four recommendations, only one of which, a significant increase in her anxiety medication, could have had any impact on her condition. The assessment was handwritten and faxed to the facility.[49] There was a delay in implementing the recommendations, since the document was unreadable. The Facility made repeated requests for clarification of the information, but the necessary information was not provided.[50] On January 28, 2005, a typed version of the report was submitted. Upon receiving the report, Resident 16's physician reduced her dosage of Paxil (an antidepressant). No other changes were made. The physician told staff that he would not increase the medication as directed in the psychologist's assessment, because the clinical condition of the resident did not support that change.[51] Resident 16 was examined again by her physician on February 25, 2005. No changes were made to Resident 16's psychoactive medications.

On March 7, 2005, Resident 16's physician and her psychologist could not agree on who should be responsible for making changes to her medications. On March 11, 2005, Resident 16 underwent a psychiatric assessment. The psychiatrist made a slight increase in Resident 16's anti-anxiety medications.

At the request of the surveyors, the nursing notes for Resident 16 were examined for notations regarding anxiety. There were 55 incidents in December 2004, 37 incidents in January 2005, and 14 incidents in February 2005.[52] The surveyors concluded that the delay in adjusting Resident 16's medication caused her harm because she continued to experience anxiety.[53]

The surveyors were correct in assessing a violation of the cited standard for Lake Ridge's failure to follow up successfully on the illegible assessment form. The surveyors erred when they founded that Resident 16 was harmed by the delay in changing her medication. Under 42 C.F.R. 483.13(a), a resident has the right to be free from medications not required to treat that resident's medical symptoms. Resident 16's

condition was improving under her existing medication regimen and the psychologist's conclusion that her medications needed to be increased significantly was shown to be erroneous, when she demonstrated a decrease in symptoms by acclimatizing to the facility. Further, the medical doctor responsible for prescribing medication indicated that he would not have changed the medication as indicated by the assessment because there was no clinical indication that the change would be appropriate. The adjustment to her anti-anxiety medication made by the psychiatrist came only after Resident 16 reached her baseline condition.

The conduct cited by the surveyors constitutes a violation of 42 C.F.R. 483.13(a). The surveyors erred in finding that the situation constituted immediate jeopardy. This violation is isolated and presents a potential for harm that is more than minimal but not immediate jeopardy and is appropriately assigned to level D on the F224 tag.

The surveyors maintained that the delay in Resident 16's psychological assessment being reviewed constitutes a deficiency supporting the F250 tag. As found above, the medical doctor refused to change Resident 16's medication as recommended by the psychologist. The finding that additional medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident was not provided to Resident 16 was in error, since only the medical doctor could change her medications and he refused to, because change was not clinically indicated. There is no factual support for the finding of a deficiency for the F250 tag for Resident 16.

Resident 17

Resident 17 is an 87-year-old woman who suffers from a dementia and required nursing care after suffering injuries from a fall. She entered Lake Ridge on October 24, 2004. Her husband, who also suffers from dementia, visited her at Lake Ridge on a frequent basis. Many of these visits occurred without incident.[54] Starting with a visit on November 10, 2004, the husband exhibited agitation and anger while conversing with their adult daughter. After this incident, Resident 17's plan of care was modified to require staff to intervene when her husband was being verbally abusive.[55]

On November 17, 2004, the husband told Resident 17 that he was going to commit suicide. Resident 17 asked a staff member to intervene and the Facility's social worker was brought in to talk to both Resident 17 and her husband.[56]

On December 17, 2004, the husband appeared at Lake Ridge at 3:10 a.m. demanding to see Resident 17. Only after the intervention of a supervisor was the husband convinced to go home and return during visiting hours.[57]

On December 20, 2004, a social worker for Ramsey County Adult Protective Services contacted the husband. The husband again made threats of suicide and divorce in an effort to get his way.[58]

On December 21, 2004, the husband visited Resident 17 and threatened to no longer visit her because the cost of the Facility's care was too expensive. A staff member intervened when Resident 17 became upset. The husband returned to her room three times to voice repeatedly the claim that he would not come to visit. After the husband finally left, the staffer stayed with Resident 17 to calm her.[59]

On December 30, 2004, Resident 17's plan of care was modified to address the issues that had arisen due to her husband's behavior. The husband was to be monitored and staff would intervene to redirect inappropriate behavior. The changes were explained to the nursing staff and care staff.[60] A later modification to the plan of care directed staff to keep the ombudsman and Adult Protective Services aware of the situation and pass on any changes in behavior.[61]

On January 2, 2005, the husband told Resident 17 that he would quit eating and "just die."[62] The context of the conversation was the husband's ongoing desire to have Resident 17 back at home. The husband also began making threats to divorce Resident 17 if she did not return home. Resident 17 also became upset during this period if she did not hear from her husband. Adult Protective Services was contacted during this period due to the husband's continued proposals to move Resident 17 back to her home without supports.[63]

On January 24, 2005, the husband visited Resident 17 and told her that she had been bad, she was never coming home, and that she would never see him again. Resident 17 became upset at these statements. A nurse intervened and the husband left.[64]

A social service progress note was completed on Resident 17 on February 25, 2005. The husband's behavior was identified and a statement from family members was noted that the husband had been engaging in abusive statements for "many years."[65] The Facility's contact with the ombudsman and Adult Protective Services was noted. Their advice, to intervene only when the husband was upsetting Resident 17 and ask the husband to step away and give her a break, was noted.[66]

From December 21, 2004 to March 7, 2005, the husband made increasingly strenuous efforts to get Resident 17 returned home or transferred to another facility. These efforts included contacting the Minnesota Attorney General's Office, a private attorney, and other care providers. The inability of the husband to obtain a desired outcome regarding Resident 17's placement came to a head on March 7, 2005.[67]

On the evening of March 7, 2005, staff heard Resident 17 crying in the kitchen area and observed the husband telling Resident 17 that she could not come home and that she would remain at the Facility until she died. Staff intervened and asked the husband to leave. He began arguing and refused to go. The Facility program manager intervened and the husband struck her on the shoulder, while making threats.[68] The husband was convinced to leave the Facility. Before he left, the husband was informed that a contract would need to be drawn up regarding his not striking anyone before he

would be allowed to visit again. This was the first instance of the husband striking anyone.

The Administrator of Lake Ridge immediately directed that signs be prepared notifying staff that the husband was not allowed on the premises and that 911 was to be called if he did not leave.[69] Resident 17's daughter was advised of the situation. By March 9, 2005, the instructions had been formalized as an education form, fully advising staff of the procedure to be followed should the husband appear and including a photograph of the husband to assist in identification.[70] Resident 17 told staff that she was concerned about her husband because he had not called or visited by March 9, 2005.[71]

Based on staff interviews and a comparison with the nursing notes, the surveyors concluded that there was no assessment of the husband's pattern of abusive behavior.[72] This finding is in error. The social service progress notes clearly document the behaviors exhibited and indicate that Adult Protective Services was involved early on in Resident 17's stay in Lake Ridge.[73] Staff followed the instructions of Adult Protective Services in regard to the husband's demonstrated behavior. Had this behavior been determined to constitute abuse by Adult Protective Services, a further obligation by the Facility to take action would have arisen. When the husband demonstrated behavior outside of the normal interaction between Resident 17 and her husband, Lake Ridge took immediate and effective action to prevent that behavior.[74]

The surveyors also asserted the interactions between Resident 17 and her husband had the potential to adversely affect the quality of life of other residents in the dementia unit. The surveyors did not address the right of Resident 17 to have visitors of her choice while at the Facility. Under 42 C.F.R. 483.15(b), "the resident has the right to -- … (2) Interact with members of the community both inside and outside the facility." This includes family members. The Facility's administrator testified that he felt excluding the husband before the physical assault of a staffer would not have been legally sustainable.[75] The Facility's program manager indicated that staff positioned themselves to intervene immediately upon Resident 17's becoming upset.[76] The surveyors erred in not recognizing the right of Resident 17 to have the visitors of her choice. The cited deficiency is not supported by the evidence.

The surveyor's basis for the F250 tag respecting this resident appears to be that the Facility did not have a licensed social worker assigned full-time to Resident 17's unit. The factual record regarding Resident 17's care shows that she was provided the services identified in her care plan and that a variety of social services were made available to both her and her husband. The surveyors erred in finding that Resident 17 was not provided sufficient social services. The cited deficiency in the F250 tag is not supported by the evidence.

Resident 20

Resident 20 is a 38-year-old man who suffers from amyotrophic lateral sclerosis (ALS or "Lou Gehrig's Disease") and obstructive sleep apnea. Due to a related

condition, Resident 20's speech is nearly incomprehensible.[77] A Bi-PAP (bi-level positive airway pressure) machine was provided by physician's order to assist Resident 20 with his breathing. For a number of reasons, Resident 20 does not always use the Bi-PAP machine. When not using the Bi-PAP machine, Resident 20 is at risk of suffering harm from insufficient oxygen intake.

The Facility explained that Resident 20 is cognitively aware and experiencing difficulties in the recent limitations that his condition has imposed. The Facility has made great efforts to assure that Resident 20 is making his own choices and that his dignity is respected. Resident 20 communicates with a board, where words can be spelled out or yes or no questions answered immediately.

During the survey, Resident 20's mother related an incident where he had his call light placed out of reach by a staff member. She related that other residents used their call light to obtain staff assistance for Resident 20. An unidentified resident confirmed the call light incident. The surveyor asked Resident 20 if his call light was within reach 50% of the time and Resident 20 responded "no" using his communication board. He responded "yes" to the question of whether staff purposely removed his call light.[78]

Resident 20's mother also passed along complaints about toileting issues, particularly Resident 20's being left with a bedpan, resulting in spills and soiling.[79] During the survey, Resident 20's mother indicated that she did not think that Lake Ridge was working with Resident 20 on bereavement issues resulting from the death of his father.[80]

The Facility maintains that the questions asked Resident 20 about the call light were ambiguous. The Administrative Law Judge disagrees. Resident 20 was aware of what he was being asked and his answers are consistent with the other evidence available on the issue. The surveyors have demonstrated that the call light deficiency is supported by the evidence. The failure to have the call light within reach when there is a potential for respiratory distress and the resident has impaired communication abilities does constitute immediate jeopardy. The scope and severity level of Level K assigned to the deficiency is correct.

The surveyors have demonstrated that there was a failure to address promptly Resident 20's toileting issues. The evidence demonstrates that Resident 20 was left with a urinal on several occasions resulting in Resident 20's being soaked in urine for a significant period of time. The failure to have the toileting conducted in a proper fashion does constitute harm, but does not rise the level of immediate jeopardy. The deficiency is isolated and presents a potential for harm that is more than minimal, but not immediate jeopardy and is appropriately assigned a level D on this portion of the F224 tag.

Resident 20's father died unexpectedly in November 2004. The surveyors cited the Facility for a lack of notation on bereavement supports and suggested that such supports had not been offered. The surveyors found a deficiency regarding the

obligation to provide social services under 42 C.F.R. 483.15(g) and issued an F250 Tag which determined that the violation was appropriately assigned Level H.[81]

The Facility responded that Resident 20 was difficult to communicate with, due to his physical condition. In addition, bereavement supports were offered and refused.[82] The effort to provide bereavement supports was insufficiently documented to meet the standard required under 42 C.F.R. 483.15(g). Since the supports were offered and refused by Resident 20, the surveyors erred in finding the supports were not offered and the failure to offer the supports caused actual harm. The appropriate severity and scope of the deficiency for failure to document are appropriately assessed as isolated and amounting to no actual harm, resulting in a Level A deficiency.

F250

Resident 3

Resident 3 is a 55-year-old woman suffering from morbid obesity, renal failure, and right ankle amputation. She had had a pacemaker implanted and she uses a colostomy bag. Resident 3 was admitted to Lake Ridge on May 5, 2004, to address the wound on her remaining foot.[83] A social services assessment was conducted regarding Resident 3's coping skills, behaviors, and interactions with others. Resident 3's behaviors regarding crying out and disturbing roommates were noted.[84]

Resident 3 is difficult to get along with, due to her behavior toward other residents and staff. Also, she exhibited trouble with hygiene, resulting in trouble with odors accompanying Resident 3.[85] Social service notations were made weekly, with the bulk of the notations directed towards obtaining changes in Resident 3's interpersonal behavior. Resident 3's desire for a private room was noted.[86] The Facility placed her in a private room due to behaviors toward other residents.[87] Efforts to address Resident 3's obesity were met with comments such as "it's my life and this is what I want to eat."[88] Resident 3 was frequently observed eating snack foods, such as cookies, chips, and soda, in addition to her prescribed diet.

Due to her weight and other physical problems, Resident 3 had trouble moving herself in bed. Early in her stay at Lake Ridge, staff attempted to address this situation by ordering a bariatric bed (designed for obese persons). The bed was received and refused by Resident 3.

When Resident 3 was interviewed by the surveyors, she indicated that she felt like a chore for staff. She also indicated that if she had a bigger bed, that she would be more mobile. Resident 3 said that she had spoken to social services in the past but nothing had changed, so she saw no point in talking to the social worker."

After the survey, the Facility again ordered a bariatric bed. When it was received, Resident 3 again indicated that she did not like it, so the bariatric bed was returned. In a conversation with the Facility's Director of Social Services, Resident 3 indicated that she was accepting of her obesity.[89] Resident 3 also indicated that she was not bothered by staff having to provide her cares.[90]

The surveyors concluded that Lake Ridge was in violation of 42 C.F.R. 483.15(g) for failure to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of Resident 3. The surveyors assigned level H to the deficiency.[91]

The finding of a deficiency regarding Resident 3 is erroneous. Lake Ridge assessed Resident 3 for her social service needs and conducted weekly follow-up. Resident 3's only request was for a private room, and that request was granted. Her other comments to the surveyors are reflective of Resident 3's own self-image, not a failure by the Facility to provide any needed social services.

F309

Resident 4

Resident 4 is 36-year-old man who is a paraplegic. He was admitted for wound care. Resident 4 had a prescription for pain medication to be taken as needed (PRN). The staff's experience with Resident 4 is that he is a very independent person and he can be very impatient.

On March 4, 2005, Resident 4 requested pain medication at or after 11:00 p.m. The nurse on duty was busy providing care to other residents. At about 12:15 a.m., Resident 4 transferred himself to his wheelchair. The nurse was in the hallway with Resident 4's medication and it was offered to him. Resident 4 maneuvered his wheelchair past the nurse and repeatedly demanded that the nursing assistant enter the code to open the door to the facility. When the door was opened, Resident 4 went to his adaptive van, followed by the nurse and nursing assistant, who urged him to return to the facility. Resident 4 refused and drove home, where he took his own pain medications. He was back at the facility in about twenty minutes.

Prior to the survey, Lake Ridge initiated an investigation into the incident. Interviews with Resident 4 and staff were conducted. The surveyors interviewed Resident 4 and he said that he had been dealing with the medical profession all his life and that the incident regarding the medication was typical.

The surveyors found a deficiency under the quality of care provision of 42 C.F.R. 483.25 which requires that a facility provide "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being [of a resident] …. The surveyors found that Resident 4 experienced actual harm and assigned a scope and severity level G to the deficiency.[92] The failure to either bring the medication or explain the delay to Resident 4 is a deficiency. The surveyor's finding that the deficiency caused actual harm is erroneous. Resident 4 went past the nurse offering the pain medication and willfully delayed taking that medication. Under those circumstances, no harm can be found to Resident 4. The appropriate scope and severity for the deficiency is Level D (isolated, no actual harm with potential for more than minimal harm).

Resident 22

Resident 22 is 90-year-old woman who was admitted in June 2003 with a fractured leg. She suffered from ongoing leg pain. Resident 22 had a standing order for pain medication to be given at bedtime.[93]

On February 21, 2005, Resident 22 put on her call light to request pain medication due to her experiencing more pain than usual. She had received her bedtime medication. The Resident 22 related to the surveyors that the nursing assistant who responded to call light refused to give her additional pain medication, since Resident 22's pain medication was directed to be given to her at bedtime per her chart. Resident 22's second use of the call light resulting in a staffer responding, but no pain medication was provided. No request was put in with the Facility physician for additional pain medication. No other pain relieving alternatives, such as heat or massage were attempted at the time Resident 22 requested assistance.

The surveyors inquired of Lake Ridge staff, and the charge nurse indicated that the problem had been one of communication between the nursing assistant and the RN on duty. The Facility physician could have been informed, or the RN could have attempted to use other pain relieving alternatives, such as heat or massage. The situation with Resident 22 was not communicated to the RN, so no effort at pain relief was attempted.

The surveyors found a deficiency regarding the quality of care provision.[94] The surveyors found that Resident 22 experienced actual harm and assigned a scope and severity level G to the deficiency.[95] The failure to pass along the request for additional pain medication by Resident 22 is a deficiency. The surveyor's conclusion that the deficiency caused actual harm is supported by the evidence. The assignment of Level G is also supported.

R.C.L.

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[1] Beverly Healthcare owns Lake Ridge, along with approximately 30 other facilities.
[2] OHFC Exhibit F-1.
[3] OHFC Exhibit Q-1.
[4] OHFC Exhibit Q-1.
[5] F224 Facility Ex. 8.
[6] F224 Facility Ex. 8.
[7] F224 Facility Ex. 5.
[8] F224 Facility Ex. 1.
[9] F224 Facility Ex. 2.
[10] *Id*.
[11] F224 Facility Ex. 3
[12] F224 Facility Ex. 4.
[13] *Id*.
[14] F224 Facility Ex. 6.
[15] F224 Facility Ex. 3.
[16] F224 Facility Ex. 3.
[17] F224 Facility Ex. 7.

[18] F224 Facility Ex. 7.
[19] *Id*.
[20] F224 Facility Ex. 8.
[21] F224 Facility Ex. 11.
[22] F224 Facility Ex. 10.
[23] OHFC Exhibit G-26a.
[24] OHFC Exhibit G-28a.
[25] OHFC Exhibit G-28a.
[26] OHFC Exhibit G-29a.
[27] OHFC Exhibit G-31a.
[28] The chart notes that Resident 12 was upset because he did not get his pain medications "right away." OHFC Exhibit G-31a.
[29] OHFC Exhibit G-31a.
[30] OHFC Exhibit G-32a.
[31] *Id*.
[32] F224 Facility Ex. 18.
[33] OHFC Exhibit G-33a.
[34] F224 Facility Ex. 19.
[35] F224 Facility Ex. 20.
[36] F224 Facility Ex. 21.
[37] OHFC Exhibit G-33a.
[38] OHFC Exhibit G-35a.
[39] OHFC Exhibit G-39a.
[40] F224 – R. 12 Facility Ex. 22.
[41] OHFC Exhibit G-35a.
[42] F224 – R. 12 Facility Ex. 24.
[43] OHFC Exhibit G-38a-39a.
[44] OHFC Exhibit F-1 (F224 tag).
[45] 42 C.F.R. 483.15(g)(1).
[46] OHFC Exhibit Q-1 (F224 tag).
[47] None of Resident 12's medical records indicates that he suffered even so much as a bruise in his attempts at self-injury.
[48] F224 R-16 Facility Ex. 5.
[49] F224 R-16 Facility Ex. 2.
[50] Testimony of Joy Hellen, Tape 1.
[51] *Id*.
[52] OHFC Exhibit F-28.
[53] OHFC Exhibit F-29.
[54] Testimony of Lage, Tape 1.
[55] OHFC Exhibit H-31.
[56] OHFC Exhibit H-37.
[57] OHFC Exhibit H-37-38.
[58] F224 R-17 Facility Ex. 4.
[59] OHFC Exhibit H-56.
[60] OHFC Exhibit H-57.
[61] OHFC Exhibit H-20.
[62] OHFC Exhibit H-39.
[63] OHFC Exhibit H-57-58.
[64] OHFC Exhibit H-39.
[65] F224 R-17 Facility Ex. 5.
[66] *Id*.
[67] OHFC Exhibit H-56-61.
[68] OHFC Exhibit H-39-40.
[69] OHFC Exhibit H-62.
[70] F224 R-17 Facility Ex. 8
[71] OHFC Exhibit H-63.

[72] OHFC Exhibit F-18.
[73] Testimony of Lage, Tape 1.
[74] The action taken to prevent the behavior, barring the husband from visiting, itself caused Resident 17 to be concerned. Resident 17's adult daughter expressed the need for the husband to be able to visit, even after the violent outburst. OHFC Exhibit F-21.
[75] Testimony of Marchant, Tape 1. The Administrative Law Judge agrees with that assessment.
[76] Testimony of Lage, Tape 1.
[77] F224 R-20 Facility Ex. 1.
[78] OHFC Exhibit F-24.
[79] F224 R-20 Facility Exs. 2 and 4.
[80] OHFC Exhibit Q-11.
[81] OHFC Exhibit Q-10-11.
[82] Testimony of Lage, Tape 1.
[83] The amputation was required due to a nonhealing wound.
[84] F250 R-3 Facility Ex. 3.
[85] OHFC Exhibit R-4.
[86] F250 R-3 Facility Ex. 3.
[87] F250 R-3 Facility Ex. 3.
[88] F250 R-3 Facility Ex. 6.
[89] F250 R-3 Facility Ex. 8. Resident 3 was snacking on peanuts during the conversation.
[90] *Id*.
[91] OHFC Exhibit F-1 (F224 tag).
[92] OHFC Exhibit X-1.
[93] OHFC Exhibit Z-21.
[94] 42 C.F.R. 483.25
[95] OHFC Exhibit X-1.